MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07865

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:

County: Carroll Co.

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 35 years

Hospital, institution, or street address where death occurred:

54 Carroll St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 54 Carroll St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Edward Myer Albert

3.(b) Social Security Number

none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	widowed

6.(b) Name of husband or wife: Lizzie Wagner Albert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 20, 1864

8. AGE:

Years	Months	Days	If less than one day
81	7	9	..... hrs. ..... min.

9. Birthplace: Adams Co. Pa.

(Town, county, and state)

10. Usual occupation: retired

11. Industry or business

FATHER

12. Name: Samuel Albert

13. Birthplace: Pa.

MOTHER

14. Maiden name: Sarah Myers

15. Birthplace: Pa.

16. Informant: Miss Mabel R. Albert

Address: 54 Carroll St. Westminster Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 1/45 (month) (day) (year)

Cemetery or crematory: Plainfield Church of Md.

Location: Plainfield, Cumberland Co. Pa.

18. Funeral director: J. E. Myers Jr.

Address: Westminster Md

19. 8/31/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29th 1945 at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 29th 1945 to August 29th 1945

and that I last saw h... alive on August 29th 1945

Immediate cause of death	DURATION
Lobar Pneumonia	3 days.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Charles Bon M. D. or other

Address: Westminster Md Date signed: 8/31/45

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07866 77

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Hampstead
(If outside city or town limits, write RURAL and give nearest town)
Street No. .....
(If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Albert S Algire

3.(b) Social Security Number 215-01-5247

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife Helen M Algire
6.(c) If alive, give age 55 years
7. Birth date of deceased (mo., day, yr.) Dec 8-1883

8. AGE:

Years	Months	Days	If less than one day
61	8	3	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation Retired Salesman
11. Industry or business Furniture

FATHER
12. Name Thomas Algire
13. Birthplace Md

MOTHER
14. Maiden name Rachel Jackson
15. Birthplace Md

16. Informant Mrs Helen M Algire
Address Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 14/42 (month) (day) (year)
Cemetery or crematory Hampstead
Location Hampstead Md
18. Funeral director Edw S Gipston
Address Hampstead Md
19. August 13 1945 John S. Hughes Jr.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1945 at 3:20 p.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 16 1945 to Aug 11 1945
and that I last saw h.. alive on Aug 11 1945

Immediate cause of death	DURATION
Carcinoma Sigmoid	1 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma of Sigmoid Date of op. 2-16-45
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Maurice C. Cartwright M. D. or other
Address Hampstead Md Date signed 8/13/45

07867

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 22 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince George's
City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)
Street No. 816 Talbot Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME
~~SAMUEL~~ AMERICA, Samuel

3.(b) Social Security Number
705-07-7575

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	Married

6.(b) Name of husband or wife Florence America
6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) April 27, 1889

8. AGE: Years	Months	Days	If less than one day
56	3	19	....hrs. ....min.

9. Birthplace Annapolis, Md.
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business Unknown
FATHER 12. Name John America
13. Birthplace Unknown
MOTHER 14. Maiden name Hattie Johnson
15. Birthplace Unknown
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial 8/18 (Burial, cremation, or removal. Which?) Date thereof 8/18/45 (month) (day) (year)
Cemetery or crematory Bachelors Cabel
Location Near Laurel md
18. Funeral director Ridgley Selby
Address 401 Washington Laurel md
19. 8/15 (Date rec'd by registrar) 19 45 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15, 1945 at 2.15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1945 to Aug. 15, 1945 and that I last saw him alive on August 15, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....
Autopsy results ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 8/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

07868

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Finksburg RFD

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1½ yrs

Hospital, Institution, or street address where death occurred: Finksburg RFD

How long in hospital or institution? -

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Finksburg RFD

(If outside city or town limits, write RURAL and give nearest town)

Street No. Deer Park Road

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Joseph George Ballard

3.(b) Social Security Number: 214-14-0062

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	M

6.(b) Name of husband or wife: Annie Florence Ballard

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): August 20 1864

8. AGE: Years	Months	Days	If less than one day
80	11	19	....hrs. ....min.

9. Birthplace: Orange Va (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: -

FATHER — 12. Name: Winfield Ballard

FATHER — 13. Birthplace: Orange Va

MOTHER — 14. Maiden name: Mildred Clark

MOTHER — 15. Birthplace: Virginia

16. Informant: Mrs Annie F Ballard

Address: Reisterstown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 11 1945 (month) (day) (year)

Cemetery or crematory: Pleasant Hill Cemetery

Location: Owings Mills Md

18. Funeral director: Wm Berryman & Sons

Address: Reisterstown Md

Aug 10 19 45 (Date rec'd by registrar) A Ray Fogle Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8/9/45 19.... at 7 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1935 19.... to 1945 19....

and that I last saw him alive on 8-8-45 19....

Immediate cause of death	DURATION
(2) Hypertension -	
(3) Arteriosclerosis -	
Due to:	
(1) Cerebral Hemorrhage -	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results: ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... Injured at work?

23. SIGNATURE: James M Duffell M. D. or other

Address: Reisterstown Date signed: 8/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

★ 07869

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Garrett
City or town Oakland
(If outside city or town limits, write RURAL and give nearest town)
Street No. -----
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME Josiah Beckman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife ?
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 3, 1864

8. AGE: Years	Months	Days	If less than one day
81	5	4	..... hrs. ..... min.

9. Birthplace Garrett County, Maryland
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business -----

FATHER
12. Name Henry Beckman
13. Birthplace Germany

MOTHER
14. Maiden name ? Lower
15. Birthplace Garrett County, Md.

16. Informant Records of Springfield State
Address Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 9, 1945 (month) (day) (year)
Cemetery or crematory Pleasant Valley Cemetery
Location 3 mi So. Oakland
18. Funeral director Herbert E. Leighton
Address Oakland, Md.
19. Aug 7 1945 C. Henry Teets
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1945, at 7 32 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12 1945, to Aug 6 1945
and that I last saw him alive on Aug 6 1945

Immediate cause of death	DURATION
Chronic Myocarditis	?
Due to Generalized Arteriosclerosis	?
Due to	
Other conditions Hypertension & Cerebral Arteriosclerosis	?

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Arnold H. Eichert M.D.
M. D. or other
Address S. Side Hoop, Sykesville Md. Date signed 8-7-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

67870

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Glyndon
(If outside city or town limits, write RURAL and give nearest town)
Street No. 207 Central Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Mary Virginia Belt

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: George M. Belt
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): November 29, 1870

8. AGE:	Years	Months	Days	If less than one day
	74	9	2	____ hrs. ____ min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: ----

FATHER
12. Name: John D. Belt
13. Birthplace: Maryland

MOTHER
14. Maiden name: Miriam Ausburn
15. Birthplace: Maryland

16. Informant: Records of Springfield State
Address: Hospital, Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 3, 1945 (month) (day) (year)
Cemetery or crematory: Pleasant Grove
Location: Balto. Co.

18. Funeral director: J.F. Eline & Sons
Address: Reisterstown, Md.

19. Sept 1 1945 (Date rec'd by registrar) Harry Green Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 1945 at 7:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 1945 to Aug. 31 1945 and that I last saw her alive on Aug. 31 1945

Immediate cause of death	DURATION
cerebral hemorrhage	1 days
Due to generalized arteriosclerosis	
Due to	
Other conditions arthritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: Helmut Traser M.D. M. D. or other
Address: Springfield Hosp. Hospital Date signed: 8/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

07871

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr., 6 mo., 23 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 1 yr., 6 mo., 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Springs
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8112 Hartford Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Morris Berry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Tina
6.(c) If alive, give age: ____ years
7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years	Months	Days	If less than one day
69 (?)			____ hrs. ____ min.

9. Birthplace: Poland
(Town, county, and state)
10. Usual occupation: Furrier
11. Industry or business
FATHER 12. Name: York
13. Birthplace
MOTHER 14. Maiden name: York
15. Birthplace
16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland
17. Cremation (Burial, cremation, or removal, Which?) Date thereof: Aug. 28, 1945 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Washington, D.C.
18. Funeral director: W. W. Chamber 6
Address: Wash. D.C.
19. Aug. 27 1945 (Date rec'd by registrar) C. Henry Lee Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27 1945, at 4:05a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 27 1944, to August 27 1945 and that I last saw him alive on August 26 1945

Immediate cause of death	DURATION
Arteriosclerosis	4 years
Due to	
Due to	
Other conditions: Psychosis with cerebral arteriosclerosis	4 years

(Incinde pregnancy within 3 months of death)
Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Robert Bertrand May, M.D.
Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed: 8-27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

07872

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mo., 14 days
Hospital, Institution, or street address where death occurred:
Maryland T.B.Sanatorium(Colored)
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County CAROLINE
City or town FEDERALSBURG
(If outside city or town limits, write RURAL and give nearest town)
Street No. RELIANCE ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: AUBREY HIX CANNON

3.(b) Social Security Number: 213-22-8135

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JULY 24, 1907

8. AGE: Years	Months	Days	If less than one day
38	0	18	..... hrs. ..... min.

9. Birthplace FEDERALSBURG, MD.
(Town, county, and state)

10. Usual occupation TAILOR

11. Industry or business

FATHER
12. Name ALBERT CANNON
13. Birthplace PRESTON, MD.

MOTHER
14. Maiden name ESTHER HORNER
15. Birthplace FEDERALSBURG, MD.

16. Informant REUBEN HOFFMAN, MD.
Address HENRYTON, MD.

17. Burial
(Burial, cremation, or removal: Which?) Date thereof Aug. 15, 1945 (month) (day) (year)
Cemetery or crematory Federalsburg
Location Federalsburg, Md.

18. Funeral director Adams & Williamson
Address Federalsburg, Md.

19. AUG. 12 1945 (Date rec'd by registrar) Albert R. Swanborn DEPUTY LOCAL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 12 1945, at 6:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from JUNE 28 1945, to AUG. 12 1945
and that I last saw h... im ...alive on AUG. 12 1945

Immediate cause of death	DURATION
PULMONARY TUBERCULOSIS	DEC. '44
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman, M.D.
M. D. or other
Address HENRYTON, MD. Date signed 8-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-b)

07873

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 months, 10 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 9 months, 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: rural near New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence Edward Cantwell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 19, 1882

8. AGE: Years	Months	Days	If less than one day
62	10	1	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Agriculture

FATHER
12. Name: Louis Henry Cantwell
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah Green
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 22-1945 (month) (day) (year)
Cemetery or crematory: Pipe Creek Cemetery
Location: Uniontown Road
18. Funeral director: H. D. Hartzler & Sons
Address: Johnsontown Bridge New Windsor Md.
19. Aug. 20 1945 C. Harry Wenz
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1945 at 11:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 1945 to Aug. 19 1945 and that I last saw him alive on August 19 1945

Immediate cause of death	DURATION
Cerebral thrombosis	48 hrs.
Due to: Arteriosclerosis, prior to	1943
Due to:	
Other conditions: Psychosis with cerebral arteriosclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.
Springfield State Hospital M. D. or other
Address: Sykesville, Maryland Date signed 8-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07874

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs. 5 Mo's, 8 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1308 E. Eager St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MANNING CANTY

3.(b) Social Security Number: 249-24-7683

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Marie Canty
8.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): July 4, 1920

8. AGE:	Years	Months	Days	If less than one day
	25	1	23	....hrs. ....min.

9. Birthplace: Sumpter, N. C.
(Town, county, and state)
10. Usual occupation: Ship Yard Worker
11. Industry or business

FATHER
12. Name: Tom Canty
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sophie Osbourne
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: Aug. 31, 1945 (month) (day) (year)
Cemetery or crematory: Hraton Creek Cem.
Location: Near Camden, S. C.
18. Funeral director: C. Harry Weir
Address: Sykesville, Md.

19. 8/27 19 45 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 27, 1945 at 3.00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1943 to Aug. 27, 1945 and that I last saw him alive on August 27, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	1-6-43
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 8/27/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 1 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07875

Reg. Diat. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Waldorf
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3. (a) FULL NAME
CATHERINE CECELIA CHASE

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 13, 1929

8. AGE:	Years	Months	Days	If less than one day
	15	10	16	hrs. min.

9. Birthplace Waldorf, Md.
(Town, county, and state)
10. Usual occupation Scholar
11. Industry or business at school
FATHER 12. Name William Chase
13. Birthplace Germantown, Md.
MOTHER 14. Maiden name Dorothy Stewart
15. Birthplace Waldorf, Md.
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial Date thereof 9 1 45
(Burial, cremation, or removal, which?) (month) (day) (year)
Cemetery or crematory H. Peters
Location Waldorf, Md
18. Funeral director Hunt & Ryon
Address Waldorf, Md.
19. 8/29 1945 Albert A. Swanson Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 29, 1945 at 1.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25, 1945 to Aug., 29, 1945 and that I last saw her alive on August 29, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	April 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman, M. D.
M. D. or other
Address Henryton, Md. Date signed 8/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

07876

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (12-6)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 4 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Prince Geo's
City or town Brentwood
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4102 Webster St.,
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: WILSON JONES CHAVERS

3.(b) Social Security Number: 577-03-4360

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married (seperated)

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 20, 1903

8. AGE:	Years	Months	Days	If less than one day
	42	4	7	....hrs. ....min.

9. Birthplace Lynchburg, N. C.
(Town, county, and state)

10. Usual occupation Presser

11. Industry or business

FATHER
12. Name James R. Chavers
13. Birthplace Lynchburg, N. C.

MOTHER
14. Maiden name Lucy Wilson
15. Birthplace Lynchburg, N. C.

16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 9-1-45 (month) (day) (year)

Cemetery or crematory PAYNES
Location Washington D. C.

18. Funeral director L. C. Lyman-Sr.
Address 1337-10 St N.W. Wash. D. C.

19. 8/27 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 27, 19 45 at 10.40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 23, 19 45 to Aug., 27, 19 45 and that I last saw him alive on August 27, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	5-1-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman, M. D.
M. D. or other
Address Henryton, Md. Date signed 8/27/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

07877

Reg. Dist. No. 24

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 mo 11 da
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 2 mo 11 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County —
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Gerda Gertrude Claus

3.(b) Social Security Number

4. Sex F
5. Color or race W
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife —
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) April 6th 1878
8. AGE: Years 67 Months 3 Days 29 If less than one day ... hrs. ... min.
9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business at home
FATHER 12. Name Charles Schaum
13. Birthplace Maryland
MOTHER 14. Maiden name Marie Salchow
15. Birthplace Germany
16. Informant Margaret Temple Chieri
Address 70 B Gittings Ave Balto
17. Burial Date thereof Aug 8, 1945
(Burial, cremation, or removal? Which?) (month) (day) (year)
Cemetery or crematory Loudon Park Cem.
Location Balto Md.
18. Funeral director William Cook Inc
Address 1217 St Paul St.
19. Aug. 6 1945 C Harry Weed
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5th 1945, at 6-40 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25th 1945, to Aug 5th 1945
and that I last saw her alive on Aug 5th 1945

Immediate cause of death	DURATION
Carcinoma metastasis	
Due to into lung & liver	
Duct cell	
Due to Carcinoma of breast	
Operation	Dec 1941
Other conditions Hypertension Arteriosclerosis cardiovascular disease	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Carcinoma of liver & lungs
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. J. Martin M.D.
M. D. or other
Address Sykesville Date signed 8/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07878

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1012 Vine Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: MARY VIVIAN CORBIN

3.(b) Social Security Number: 217-14-6176

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married (sep.)

6.(b) Name of husband or wife: Homer Corbin
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 3, 1920

8. AGE:	Years	Months	Days	If less than one day
	24	8	28	hrs. min.

9. Birthplace: Savannah, Georgia (Town, county, and state)
10. Usual occupation: Worker in defense plant.
11. Industry or business:

FATHER
12. Name: Tilghman Paul
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Bertha Burgess
15. Birthplace: South Carolina

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sept 6th 1945 (month) (day) (year)
Cemetery or crematory: Arbutus Memorial Park.
Location: Arbutus Md.

18. Funeral director: Mrs Katie R. Williams
Address: 322 n Schroeder St.

19. Aug. 31, 1945 (Date rec'd by registrar) Albert A. Strahan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31, 1945, at 3:25P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 1945 to August 31, 1945 and that I last saw her alive on August 31, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	March 23, 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 8-31-45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48a

07879

CERTIFICATE OF DEATH

Reg. Dist. No. 78

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Covers Corner
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Covers Corner
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: BLANCHE E. COVER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 25, 1885

8. AGE: Years: 60 | Months: 4 | Days: 7 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Columbus C. Cover
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julia A. Cashour
15. Birthplace: Maryland

16. Informant: Mrs. Bessie Brown-Braungart
Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-5-45 (month) (day) (year)
Cemetery or crematory: Pipe Creek
Location: near New Windsor, Md.

18. Funeral director: C.M.Waltz
Address: Winfield, Md.

19. Aug 4 1945 (Date rec'd by registrar) E. M. Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 2, 1945, at 1:10A; P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1st 1943, to Aug 1st 1945
and that I last saw ~~him~~ her alive on Aug 1st 1945

Immediate cause of death	DURATION
Cancer + Paralysis	1 year
Due to	
Due to	
Other conditions: Diabetes	4 years

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: L. C. Shirley M. D. or other
Address: New Windsor Md Date signed 8/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-6

07880

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Rural, Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore Corr.

City or town: Rural, Sykesville, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Laura Victor Crunkilton

3.(b) Social Security Number: 216-07-0331

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Elizabeth Mary Crunkilton

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 3, 1880

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
64	8	19		

9. Birthplace: Clarktown, Va. Clark Co.
(Town, county, and state)

10. Usual occupation: Textile Mill worker.

11. Industry or business

FATHER
12. Name: Laura Victor Crunkilton
13. Birthplace: Clarktown, Va.

MOTHER
14. Maiden name: Elizabeth Mary Mercer
15. Birthplace: Kabletown, W. Va.

16. Informant: Mrs. Martha Murray
Address: Sykesville, Md. R.7, D#1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 25 1945 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Reisterstown, Md.

18. Funeral director: Wm. Berry man & Sons

Address: Reisterstown, Md.

19. Aug. 23 1945 (Date rec'd by registrar) C. Harry Zile Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 22 1945, at 10:15 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-8- 1945 to 8-22 1945

and that I last saw him alive on 8-21 1945

Immediate cause of death	DURATION
Carcinoma of Thoracic Spine	5 mos.
Due to	
Due to	
Other conditions: Bronchitis	2 mos
Bed Sore	2 wks

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. D. Caples M. D.
M. D. or other

Address: Reisterstown, Md. Date signed: 8-23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (124-C)

CERTIFICATE OF DEATH

★ 07881 Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster (If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Penn. Ave. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Anna Maryalice Dutterer

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife Austin Dutterar 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 1 - 1865

8. AGE: Years	Months	Days	If less than one day
80	-	14	..... hrs. ..... min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation None
11. Industry or business
FATHER 12. Name William Feaser
13. Birthplace Pa.
MOTHER 14. Maiden name Not Known
15. Birthplace .. ..
16. Informant Stewart F. Dutterer
Address 114 Penn. Ave. Westminster, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof August 17-1945 (month) (day) (year)
Cemetery or crematory Westminster Cemetery
Location Westminster Md.
18. Funeral director H Bankard & Son
Address Westminster, Md
19. 8/16 1945 [signature] Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 15th 1945 at 5P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from August 1 1945 to August 15 1945 and that I last saw her alive on August 15th 1945

Immediate cause of death

	DURATION
Acute Broncho Pneumonia -	3 days
Due to Acute Bronchitis	1 week
Due to Hy. Hypertrophied Cirrhosis	1 year -
Other conditions of Long -	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE [signature] (M.D.) M. D. or other
Address Westminster Md. Date signed 8/16/45

VS A15

PLEASE WRITE PLAINLY, WITH INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07882

Reg. Dist. No. 81

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge (Rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Usher Josiah Eiler

3.(b) Social Security Number: 705-14-0310

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary C Eiler

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): February 23 - 1883

8. AGE: Years	Months	Days	If less than one day
62	5	26	____ hrs. ____ min.

9. Birthplace: Frederick Co Maryland
(Town, county, and state)

10. Usual occupation: Farmer & Telegraph Operator

11. Industry or business: Farming - Railroad

FATHER
12. Name: Charles R. Eiler
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Harwetal
15. Birthplace: Maryland

16. Informant: Chas M Eiler
Address: Union Bridge Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 22 - 1945 (month) (day) (year)

Cemetery or crematory: Mt Hope Cemetary

Location: Westminster Maryland

18. Funeral director: D.D. Hartle & Son

Address: Union Bridge & New Windsor Md

19. Aug. 21, 1945 (Date received by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1945, at 12:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__ to ____ 19__

and that I last saw him alive on ____ 19__

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh Deputy Medical Examiner
M. D. or other

Address: Westminster Md Date signed: 8/20/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07883

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs - 9 days

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 15 yrs - 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2714 Ver Barronwood St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: WILLIAM EVANS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	S

8.(b) Name of husband or wife: —

8.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): July 6, 1898

8. AGE:

Years	Months	Days	If less than one day
47	1	9	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business:

FATHER — 12. Name: Rennert Thomas Evans

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary Burns.

15. Birthplace: Md.

16. Informant: Records of Springfield state Hospital, Sykesville, Md.

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 17, 1945 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Baltimore

18. Funeral director: Rita Wiedefeld

Address: 914 Greenmount Ave

19. 8/17/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 19 45, at 6 18 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 42, to Aug. 15 19 45

and that I last saw h... alive on Aug. 14 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	13 yrs
Due to	
Due to	
Other conditions: Schizophrenia. (Include pregnancy within 3 months of death)	

Major findings of operations: ... Date of op. ...

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) ...

Means of injury: ... Injured at work?

23. SIGNATURE: Edward J. Kernan M. D. or other

Address: Sykesville, Md Date signed 8-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1621 Lamont Ave.

Pemphrey

Aug 2016

07884

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Cecil

City or town: Elkton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 yrs. 10 mo. 25 da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 9 yrs. 10 mos. 25 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wash. Co.

City or town: Hagerstown (If outside city or town limits, write RURAL and give nearest town)

Street No. 24 D Locust Street (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Ella Foxy.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: George Foxy

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 23, 1882

8. AGE:

Years	Months	Days	If less than one day
63	5	18	..... hrs. ..... min.

9. Birthplace: Limbers Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Conrad Stemmel

FATHER — 13. Birthplace: Hanover Pa.

MOTHER — 14. Maiden name: Sallie Huff

MOTHER — 15. Birthplace: Limbers Md.

16. Informant: Hospital Records

Address: Elkton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 13, 1945 (month) (day) (year)

Cemetery or crematory: Black Rock Cemetery

Location: Black Rock, Pa.

18. Funeral director: Jacob Winks Sons

Address: Manchester, Md.

19. Aug. 10 1945 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10th 1945 at 10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 26 1935, to Aug. 10 1945

and that I last saw h.. alive on Aug. 16 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	1 hr.
Due to: Arteriosclerosis	4 yrs.
Due to:	
Other conditions: Prostatic Condition	12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Maud M. Rees M. D. (M. D. or other)

Address: Elkton Md. Date signed 8-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07885

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 8 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Howard
City or town Elkridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. Church Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: LONNIE FRANKLIN, JR.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 3, 1933

8. AGE: Years	Months	Days	If less than one day
11	11	17	..... hrs. ..... min.

9. Birthplace Baltimore, Md.
(Town, county, and state)

10. Usual occupation Scholar

11. Industry or business at school

FATHER
12. Name Lonnie Franklin, Sr.
13. Birthplace Barnesville, S.C.

MOTHER
14. Maiden name Annie Hallingquest
15. Birthplace South Carolina

16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.

17. Burial (Burial, cremation, or removal. Write) Date thereof 8-23-45 (month) (day) (year)
Cemetery or crematory Mt Zion Cem—
Location Sandosdown;

18. Funeral director Mrs Katie R. Williams
Address 922 N. Schroeder St.

19. 8/20 (Date rec'd by registrar) 1945 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1945, at 2.40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12, 1945, to Aug., 20, 1945 and that I last saw him alive on August 20, 1945

Immediate cause of death: Pulmonary Tuberculosis — DURATION: May 1945

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D.
M. D. or other
Address Henryton, Md. Date signed 8/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Bal)

07886

CERTIFICATE OF DEATH

Reg. Dist. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Keysville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Keysville (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George B. Frock

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Dora Frock

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 27, 1870

8. AGE:	Years	Months	Days	If less than one day
	75	2	27	..... hrs. ..... min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name John W. Frock

13. Birthplace Md

MOTHER 14. Maiden name Laura J. Martin

15. Birthplace Md

16. Informant Mrs. Upton Dayhoff

Address Taneytown, R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 25, 1945 (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville, Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. aug 25, 1945 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 23 1945 at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 20 1945, to Aug. 23 1945 and that I last saw h.. alive on Aug. 22 1945

Immediate cause of death	DURATION
Bronchopneumonia	2 days
Due to Asthma	10 days
Due to Acute Bronchitis	10 days
Other conditions Chronic Myocarditis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE R. S. McVaugh M.D. M. D. or other

Address Taneytown, Md. Date signed Aug 24, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

07887

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 yr., 3 mo., 18 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 8 yr., 3 mo., 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Samuel Gardiner

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 12, 1881

8. AGE: Years	Months	Days	If less than one day
64	5	17	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business

FATHER
12. Name: John Gardiner
13. Birthplace: Maryland

MOTHER
14. Maiden name: Martha Ray
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 2, 1945 (month) (day) (year)
Cemetery or crematory: Centerville
Location: Centerville, Md.
18. Funeral director: Barton Geo.
Address: Centerville, Md

19. Aug 30 1945 (Date rec'd by registrar) A. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 19 45, at 1:50p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death	DURATION
Arteriosclerosis	9 yrs.
Due to	
Due to	
Other conditions: Manic-depressife psychosis, manic type	18 years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: James T. Monroe Deputy Medical Examiner M. D. or other
Address: Westminster Md Date signed: 8/29/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-F)

07888

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 9 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1619 W. Mulberry St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: ERNEST GIBSON

3.(b) Social Security Number: 216-10-6933

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): July 4, 1904

8. AGE:	Years	Months	Days	If less than one day
	41	1	17	hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Unknown
FATHER 12. Name: Frank Gibson
13. Birthplace: Baltimore, Md.
MOTHER 14. Maiden name: Unknown
15. Birthplace: Maryland.
16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 23rd / 45 (month) (day) (year)
Cemetery or crematory M't Calv.
Location Baltimore, Md.
18. Funeral director Edw. O. Wilson
Address 1000 Brantley
19. 8/21 19 45 Deputy Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21, 1945, at 1.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12, 1945, to Aug., 21, 1945 and that I last saw him alive on August 21, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1940
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D.
M. D. or other
Address Henryton, Md. Date signed 8/21/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07889

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 21 days
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St. Mary's
City or town: Dameron
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) ✓
2.(a) If veteran, name war

3.(a) FULL NAME: JAMES BERNARD GUNN, JR.

3.(b) Social Security Number: 214-16-7509

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Cora Gunn
6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): March 27, 1921

8. AGE: Years	Months	Days	If less than one day
24	4	17	hrs. min.

9. Birthplace: Dameron, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: James Gunn, Sr.
13. Birthplace: St. Mary's County, Md.

MOTHER
14. Maiden name: Daisy Briscoe
15. Birthplace: St. Mary's County, Md.

16. Informant: Reuben Heffman, M. D.
Address: Henryton, Md.

17. Burial, cremation, or removal. Which? Burial Date thereof: Aug 14, 1945 (month) (day) (year)
Cemetery or crematory: St Peter
Location: Ridge Md.

18. Funeral director: Robinson Funeral Home
Address: Leonardtown, Md

19. 8/13 (Date rec'd by registrar) 19 45 Albert R. Saunders Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13, 19 45, at 9.10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 23, 19 45, to Aug. 13, 19 45 and that I last saw him alive on August 13, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Heffman M. D. M. D. or other
Address: Henryton, Md. Date signed: 8/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07890 ★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months
Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Marbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: HELEN INEZ HANCOCK

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5, 1921

8. AGE: Years	Months	Days	If less than one day
24	3	11	hrs. min.

9. Birthplace: Marbury, Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Unknown

FATHER
12. Name: Reginald Hancock
13. Birthplace: Cross Roads, Md.

MOTHER
14. Maiden name: Mabel Henson
15. Birthplace: Marbury, Md.

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Aug 19 1945 (month) (day) (year)
Cemetery or crematory: Mt. Hope Cemetery
Location: Charles County Md.

18. Funeral director: Stanley Penny
Address: Mason Springs Md R.F.D. #1

19. 8/16 (Date rec'd by registrar) 19 45 Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 16, 1945, at 5.20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb., 16, 1945 to Aug., 16, 1945 and that I last saw her alive on August 16, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Feb. 1938
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 8/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07891

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 929 Shields Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: CATHERINE HILL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married (Sep.)

6.(b) Name of husband or wife: Willie Lee Hill
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 25, 1911

8. AGE: Years	Months	Days	If less than one day
33	8	4	hrs. min.

9. Birthplace: Prince George, Va.
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business:

FATHER
12. Name: Henry Stykes
13. Birthplace: Unknown

MOTHER
14. Maiden name: Martha Allen
15. Birthplace: Virginia

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9-1-45 (month) (day) (year)
Cemetery or crematory: Mt Auburn
Location: Baltimore md
18. Funeral director: William a Jackson
Address: 916 Penn Ave

19. Aug. 29, 1945 (Date rec'd by registrar) Albert R. Stinchcomb Deput, Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29, 1945, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 11, 1945, to Aug. 29, 1945
and that I last saw h er alive on August 29, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	April 20, 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed 8-29-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

07892

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-W)

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: CARROLL

City or town: RURAL FINKSBURG
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 YEARS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: CARROLL

City or town: RURAL FINKSBURG
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: JOHN FILLMORE HOFF

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 2, 1856

8. AGE: Years	Months	Days	If less than one day
88	9	19	..... hrs. ..... min.

9. Birthplace: LAWNDALE, CARROLL, MD.
(Town, county, and state)

10. Usual occupation: FARMER

11. Industry or business

FATHER
12. Name: JACOB M. HOFF
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: MARY UHLER
15. Birthplace: MARYLAND

16. Informant: MRS. GUY W. CARLE
Address: SANDYMOUNT, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof 8/24/45 (month) (day) (year)

Cemetery or crematory: SANDYMOUNT CEM.

Location: SANDYMOUNT, MD.

18. Funeral director: J. FRANCIS REESE

Address: WESTMINSTER, MD.

19. 8/22 19 45 (Date rec'd by registrar) T. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 21 19 45, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1, 19 42 to Aug 21 19 45

and that I last saw him alive on Aug 21 19 45

Immediate cause of death	DURATION
Myocardial degeneration	6 mos
Due to Arteriosclerosis	Indefinite
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Reese Williams M. D. or other

Address: Westminster Date signed 8/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

07893

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Greenville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Greenville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Sykesville P.O.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Theodore R. Hooper

3. (b) Social Security Number: 4

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Viola M. Hooper

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 31, 1872

8. AGE: Years	Months	Days	If less than one day
73	2	9	..... hrs. ..... min.

9. Birthplace: Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Retired

FATHER 12. Name: Frederick Hooper

13. Birthplace: Md.

MOTHER 14. Maiden name: Sarah E. ?

15. Birthplace: Md.

16. Informant: Mr. John Hooper

Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 12, 1945 (month) (day) (year)

Cemetery or crematory: Oakland Methodist Cem.

Location: Carroll Co., Md.

18. Funeral director: C. Harry Wees

Address: Sykesville, Md.

19. Aug. 11, 1945 C. Harry Wees

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9, 1945 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14, 1945 to Aug. 9, 1945 and that I last saw him alive on Aug. 8, 1945

Immediate cause of death	DURATION
Diabetes	5
Due to	
Due to	
Other conditions Diarrhea	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Date signed 8/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (48-A)

07894

CERTIFICATE OF DEATH

★ Reg. Dist. No. 24

1. PLACE OF DEATH:

County Anne Arundel

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 11 mos. 7 da.

Hospital, Institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 yrs. 11 mos. 7 da.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1323 Linden Avenue (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Marie Antoinette Tennison

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov. 3, 1874

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
70	9	10		

9. Birthplace Newark, New Jersey (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Rev. Joseph F. Tennison

13. Birthplace Lawrenceville

MOTHER 14. Maiden name Elizabeth Renton

15. Birthplace New Jersey

16. Informant Hospital Records

Address Sykesville, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 8/16/45 (month) (day) (year)

Cemetery or crematory London Park Cem.

Location Baltimore, Md.

18. Funeral director John C. Mitchell & Sons

Address 1900 Eutaw Place

19. Aug. 14, 1945 (Date rec'd by registrar) C. Harry Elseo Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 13, 1945 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 15, 1940 to Aug. 13, 1945 and that I last saw her alive on Aug. 13, 1945

Immediate cause of death	DURATION
Carcinoma of the Uterine Cervix	1 year
Due to	
Due to	
Other conditions Paranoid Condition	4 yrs. 11 mo. 7 da.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Allan M. Rees M.D. M. D. or other

Address Sykesville, Md. Date signed 8-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 078974

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months

Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Drury
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ELSIE LOUISE JOHNSON

3.(b) Social Security Number: 212-20-1988

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 19, 1923

8. AGE: Years	Months	Days	If less than one day
22	5	11	hrs. min.

9. Birthplace: Drury, Md
(Town, county, and state)

10. Usual occupation: Waitress

11. Industry or business

FATHER — 12. Name: Aaron Johnson

FATHER — 13. Birthplace: Drury, Md.

MOTHER — 14. Maiden name: Louise Chase

MOTHER — 15. Birthplace: Drury, Md.

16. Informant: Reuben Hoffman, M. D.

Address: Henryton, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 2, 1945 (month) (day) (year)

Cemetery or crematory: Mosea Cemetery

Location: Drury, Md.

18. Funeral director: T. C. Hardesty & Son

Address: Ellicott City, Md.

19. 8/30 (Date rec'd by registrar) 19 45 Albert R. Swansborough Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30, 1945 at 2.30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 30, 1944 to Aug. 30, 1945 and that I last saw her alive on August 30, 1945

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Sept. 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D. M. D. or other

Address: Henryton, Md. Date signed 8/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07896

Reg. Diat. No. 37

1. PLACE OF DEATH: County Carroll. City or town near Sykesville, Md. (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs., 4 mos., 23 days.
Hospital, Institution, or street address where death occurred: Springfield State Hospital.
How long in hospital or institution? 2 yrs., 4 mos., 23 days.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Baltimore Co.?
City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 3629 Milford Mill Road. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Michael Lindner. 3. (b) Social Security Number #

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	White.	Single.

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) February 20, 1868.

8. AGE: Years	Months	Days	If less than one day
77.	5.	16.	..... hrs. ..... min.

9. Birthplace Germany. (Town, county, and state)
10. Usual occupation General Laborer.
11. Industry or business
12. FATHER Name Joseph Lindner.
13. FATHER Birthplace Germany.
14. MOTHER Maiden name Elizabeth Wolfrans.
15. MOTHER Birthplace Germany.
16. Informant Springfield Hospital Record. Address Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 11-45 (month) (day) (year)
Cemetery or crematory Holy Redeemer
Location Baltimore Md.
18. Funeral director Ellsworth Ormacost
Address 3911 Liberty Heights Ave
19. 8/12/45 (Date rec'd by registrar) Dr E C Neahr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7, 1945 at 8.30 p. m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 31, 1943 to Aug. 7, 1945. and that I last saw him alive on August 7, 1945.

Immediate cause of death	DURATION
General Arterio-sclerosis & Hypertension - prior to	3-15-43.
Due to	
Due to	
Other conditions Senile Psychosis - simple deterioration, prior to	3-15-43.

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Harry J. Baer, M.D. M. D. or other
Address Sykesville, Md. Date signed 8-7-45.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

07897

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Eldersburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Eldersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Rural Sykesville
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Ronald Linton

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 8, 1943

8. AGE: Years	Months	Days	If less than one day
2	4	27	hrs. min.

9. Birthplace: Eldersburg, Carroll Co., Md.
(Town, county, and state)
10. Usual occupation:
11. Industry or business:
FATHER 12. Name: Harry M. Linton
13. Birthplace: Sykesville, Md.
MOTHER 14. Maiden name: Mildred Layfield
15. Birthplace: Somerset Co., Md.
16. Informant: Harry M. Linton
Address: Sykesville, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/8/45 (month) (day) (year)
Cemetery or crematory: Wesley Freedom Cem.
Location: Eldersburg, Carroll Co. Md.
18. Funeral director: C. M. Welty, Jr.
Address: Westminster, Md.
19. Aug. 7 19 45 C. Harry Weer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 5 19 45 at 10:25 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1944 19 to August 5 19 45 and that I last saw h.. alive on August 5 19 45

Immediate cause of death	DURATION
Hydrocephalus, communicating, congenital	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Wm Lamont, M.D. M. D. or other
Address: Sykesville Date signed 8/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160a)

CERTIFICATE OF DEATH

07898

Reg. Dist. No. 19

1. PLACE OF DEATH:

County Carroll

City or town Keymar R.D.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Near Detour

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Richard Myers

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31, 1945

8. AGE: Years	Months	Days	If less than one day
0	0	9	hrs. min.

9. Birthplace Carroll Co., Md. (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Raymond Myers

13. Birthplace Md.

MOTHER 14. Maiden name Catherine E. Smith

15. Birthplace Md.

16. Informant Raymond Myers

Address Keymar R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 11, 1945 (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville, Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. Aug 11 1945 (Date rec'd by registrar) Ramsay M. Fuss. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 10 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31 1945 to Aug. 10 1945 and that I last saw him alive on Aug. 9 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	24 hrs
Due to: Spina Bifida Severa & Hydrocephalus	10 days
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. V. Legg M. D. or other

Address Union Bridge Date signed 8-10-45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07899

★ Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 3 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Newport
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
MARY CATHERINE NEALE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife Joseph Neale
6.(c) If alive, give age 28 years

7. Birth date of deceased (mo., day, yr.) May 24, 1917

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
28	2	27		

9. Birthplace St. Mary's Co., Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business at home
FATHER 12. Name Wilson Cole
13. Birthplace Unknown
MOTHER 14. Maiden name Pauline Baker
15. Birthplace Unknown
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/23/45 (month) (day) (year)
Cemetery or crematory St. Marys County
Location Newtowne, Md.
18. Funeral director Hewitt & Ryan
Address Waldorf, Md.
19. 8/20 (Date rec'd by registrar) 19 45 Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 19 45 at 8.30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17, 19 45 to Aug., 20, 19 45
and that I last saw her alive on August 20, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M. D.
M. D. or other
Address Henryton, Md. Date signed 8/20/45

STATE OF MARYLAND—CERTIFICATE OF DEATH

07900

V. S. No. 1

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH

County Carroll County Registration Dist. No.

Village or City Giss No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Robert Burrell Nelson If U. S. Veteran, specify WAR

(a) Residence: No. Route 2, Sykesville, Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Louise Nelson

6. DATE OF BIRTH (month, day, and year): August 3, 1872

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73		27	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.: Pharmacist

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.: James W. Johnson

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country): West Virginia

FATHER

13. NAME: Hugh Nelson

14. BIRTHPLACE (city or town) (State or country): Unknown

MOTHER

15. MAIDEN NAME: Rose Bentley

16. BIRTHPLACE (city or town) (State or country): Unknown

17. INFORMANT: Charles D. Woodward

(Address) Route 2, Sykesville, Maryland

18. BURIAL, CREMATION, OR REMOVAL

Place Lorraine Date 9/2/ 1945

19. UNDERTAKER: WILLIAM COOK, INC.

(Address) 1217 St. Paul Street

20. FILED 9-1, 1945 Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH Aug (Month) 30 (Day) — 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from July 20, 1945, to Aug 30, 1945

last saw him alive on Aug 25, 1945; death is said to have occurred on the date stated above, at 1 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Diabetis (chr)	
Myocarditis (chr)	
Nephritis (chr)	

Other Contributory Causes of Importance:

Name of operation: None Date of:

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? None Date of injury, 19

Where did injury occur? None (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) W. C. Fennell M. D.

(Address) Westminster Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel,** etc. For a person who had no occupation whatever write **none.**

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver,** etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill,** etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer,** etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist,** etc. Distinguish carefully between **retail merchants** and **wholesale merchants.** A person who sells goods should be called a **salesman** and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07901

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs., 10 mos., 17 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 18 yrs., 10 mos., 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 48 Humbird Street (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mathias A. Niland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: ?

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 8, 1884

8. AGE:

Years	Months	Days	If less than one day
61	0	10	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Telegraph operator

11. Industry or business: Railroad

FATHER

12. Name: Mathias Niland

13. Birthplace: Ireland

MOTHER

14. Maiden name: Sarah Walsh

15. Birthplace: Ireland

16. Informant: Records of Springfield State Hospital, Sykesville, Md. Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 21, 1945 (month) (day) (year)

Cemetery or crematory: Cumberland

Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Aug. 18 1945 (Date rec'd by registrar) C. Henry Wise Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 18 1945, at 7 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1940, to Aug. 18 1945

and that I last saw him alive on Aug. 17 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 wks.
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions: Manic Depressive Psychosis (Include pregnancy within 3 months of death)	30 yrs.

Major findings of operations: ..... Date of op. .....

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Edward F. Kernan M. D. ~~or other~~

Address: Sykesville Md. Date signed 8-18-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

07902

Reg. Diat. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH.
County: Carroll
City or town: Hampstead Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Hampstead Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME E. Wesley Null

3.(b) Social Security Number 214-01-1707

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Rosa B Null
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): May 16 - 1880

8. AGE: Years 65 | Months 2 | Days 28 | If less than one day: hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Waitman

11. Industry or business: Flour Mill

FATHER 12. Name: Eli Null
13. Birthplace: Maryland

MOTHER 14. Maiden name: Susan Masenheimer
15. Birthplace: Maryland

16. Informant: Mrs Rosa Null
Address: Hampstead Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 17/45 (month) (day) (year)
Cemetery or crematory: Lutheran
Location: Carroll Co Md

18. Funeral director: Edw A Tipton
Address: Hampstead Md

19. Aug. 15 1945 John S. Hughes Jr. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 1945 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 18 1943 to August 14 1945 and that I last saw h.m. alive on August 14 1945

Immediate cause of death: Chronic Glomerular Nephritis ?

Due to: Arterio-Selerotic Cardio-Vascular Disease.

Other conditions: —

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: —
Date of op. —
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work? —

23. SIGNATURE: Joseph E. Brad M.D.
M. D. or other
Address: Hampstead Md Date signed 8-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07903

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 3 mo., 6 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 538 Oxford St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: HAZEL LENORA ODEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 10, 1933

8. AGE: Years	Months	Days	If less than one day
12	3	29	hrs. min.

9. Birthplace: New York (Town, county, and state)
10. Usual occupation: Scholar
11. Industry or business:

FATHER
12. Name: Joseph Oden
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Lenora Gaines
15. Birthplace: Baltimore, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 13, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore

18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave.

19. Aug. 9, 1945 (Date rec'd by registrar) Albert R. Swanhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9, 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 3, 1943 to Aug. 9, 1945 and that I last saw her alive on August 9, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1943
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 8-9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07904

Reg. Dist. No. 70

1. PLACE OF DEATH:

County Carrpll

City or town Taneytown, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Carroll

City or town Taneytown, (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Jeremiah D. Overholtzer

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife Rosa Crabbs

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 18, 1866

8. AGE: Years	Months	Days	If less than one day
79	5	25	hrs. min.

9. Birthplace Penna. (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name Emanuel Overholtzer

13. Birthplace Md.

MOTHER 14. Maiden name Sarah Jacobs

15. Birthplace Penna.

16. Informant Mrs. Rosa Overholtzer

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 15, 1945 (month) (day) (year)

Cemetery or crematory Reformed Cemetery

Location Taneytown, Md.

18. Funeral director C.O.Fuss & Son

Address Taneytown, Md.

19. Aug 14, 1945 (Date rec'd by registrar) Ethel M Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1945, at 7.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6th 1937, to Aug. 7th 1945 and that I last saw him alive on August 7, 1945

Immediate cause of death	DURATION
Bronchiectasis(sacular)	4yrs.
Myocarditis(chronic)	4yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Francis J. Elliot M.D. M. D. or other

Address Taneytown, Maryland Date signed Aug. 13 '45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: near Finksburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Balto.

City or town: Baltimore City

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1115 W. 36th Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: MARGARET C. PHILLIPS

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Elias H. Phillips

deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): August 24, 1883

8. AGE:	Years	Months	Days	If less than one day
	62	-	2	..... hrs. ..... min.

9. Birthplace: Penna. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: William Stonesifer

13. Birthplace: unknown

MOTHER — 14. Maiden name: Caroline Wall

15. Birthplace: unknown

16. Informant: Mr. George Phillips

Address: 1115 W. 36th St. Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-28-45 (month) (day) (year)

Cemetery or crematory: Bethesda

Location: Gist, Carroll Co. Md.

18. Funeral director: C.M. Waltz

Address: Winfield, Md.

19. 8 28 1945 (Date rec'd by registrar) — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26, 1945 at 7:A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-28-1945, to 8-26-1945

and that I last saw h... alive on 8-26-45, 1945

Immediate cause of death	Carcinoma of Colon	DURATION 2 yrs.
Due to		
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) None (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: D. D. Caplea, M. D. (M. D. or other)

Address: Reisterstown, Md. Date signed: 8-27-'45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

07906

CERTIFICATE OF DEATH

★ Reg. Dist. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Janet Lanire Reed

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

8.(b) Name of husband or wife
8.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 3. 1938

8. AGE:

Years	Months	Days	If less than one day
7	3	24	...hrs. ...min.

9. Birthplace: Manchester Md (Town, county, and state)
10. Usual occupation: at School
11. Industry or business

FATHER
12. Name: Russell O Reed
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna M Redding
15. Birthplace: Maryland

16. Informant: Russell O Reed
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-30-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Manchester Md
18. Funeral director: Jacob Winter Sons
Address: Manchester Md

19. Aug 29 1945 M.S. W.P.S. Bowers (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 27 1945 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Muscipla Fracture of Skull (Crush)	
Due to: Struck by	
Due to: Truck	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 8/27/45
Where did injury occur? Manchester (City or town) Carroll (County) Md (State)
Injured at home, farm, industry, public place (where?) State Road
Means of injury: Struck by truck Injured at work? No

23. SIGNATURE: Maurice C. Burtefield
acting Deputy Med. Exam. Coroner
Address: Carroll Co. Date signed 8/29/45
Hampstead, Md.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

07907

Reg. Dist. No. 77

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Carroll

City or town Hampstead

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 years.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Hampstead

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lucy R Rhoten

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband ~~or wife~~ David W R Rhoten

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Feb 14 1867

8. AGE:	Years	Months	Days	If less than one day
	78	5	20	hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name William Waltemyer

13. Birthplace Md

MOTHER 14. Maiden name Jane Waltemyer

15. Birthplace Md

16. Informant Mrs Clarence Pengry

Address Hampstead Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 7 45 (month) (day) (year)

Cemetery or crematory Salem - Baltimore Co Md

Location

18. Funeral director Edw C Tipton

Address Hampstead Md

19. August 6 1945 (Date rec'd by registrar) Mildred S. Hughes (Dep.) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 4 1945 at 2:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945 to Aug 4 1945

and that I last saw h alive on Aug 3 1945

Immediate cause of death	DURATION
Carcinomatosis	1 mo
Due to Carcinoma of Stomach	11/2 yr
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Maurice A Fontrier M. D. or other

Address Hampstead Md Date signed 8/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07908

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 25 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1112 Pennsylvania Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ALFONCO RICHARDSON

3.(b) Social Security Number: lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 5, 1907

8. AGE: Years	Months	Days	If less than one day
38	1	5	hrs. min.

9. Birthplace: Sylvester, Ga. (Town, county, and state)
10. Usual occupation: Longshoreman
11. Industry or business:

FATHER
12. Name: Jann Richardson
13. Birthplace: Unknown

MOTHER
14. Maiden name: Della James
15. Birthplace: Shenglers, Ga.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8/10/45 (month) (day) (year)
Cemetery or crematory: Baltimore City Morgue
Location: Baltimore, Md.
18. Funeral director: Wm. J. Travers & Henderson
Address: 578 W. Baltimore St.
19. August 10, 45 (Date rec'd by registrar) Albert Brandhorst Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 10, 1945 at 2:25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 1945 to August 10, 1945 and that I last saw him alive on August 10, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Md. Date signed: 8-10-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07909

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 26 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland. County Worcester
City or town Pocomoke City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 510 Bank Street
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: ETHEL MARIE RICKS

3.(b) Social Security Number: 213-22-4844

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 3, 1909

8. AGE:	Years	Months	Days	If less than one day
	36	1	17	..... hrs. ..... min.

9. Birthplace Camden, N. C.
(Town, county, and state)
10. Usual occupation Cook
11. Industry or business Unknown
FATHER 12. Name Henry Lamb
13. Birthplace Unknown
MOTHER 14. Maiden name Alcora Wilson
15. Birthplace Unknown
16. Informant Reuben Hoffman, M. D.
Address Henryton, Md.
17. Shipped (Burial, cremation, or removal. Which?) Date thereof 8/23/45 (month) (day) (year)
Cemetery or crematory
Location Elizabeth City, N. C.
18. Funeral director Wm A. Jackson
Address 916 Pennsylvania Ave
19. 8/20 (Date rec'd by registrar) 19 45 Albert R. Scarbrough Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1945 at 10.25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25, 1945 to Aug., 20, 1945 and that I last saw her alive on August 20, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 8/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07910

Reg. Diat. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Linebaro
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Linebaro Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Evelyn R. Rohrbaugh

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femail	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1929

8. AGE:

Years	Months	Days	If less than one day
16	7	27	hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)
10. Usual occupation: at School
11. Industry or business

FATHER
12. Name: Clinton C. Rohrbaugh
13. Birthplace: Carroll Co. Md

MOTHER
14. Maiden name: Naomi L. Thomas
15. Birthplace: Carroll Co. Md

16. Informant: Clinton C. Rohrbaugh
Address: Linebaro Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof 8-19-45 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Linebaro Md
18. Funeral director: Jacob Winter's Sons
Address: Manchester Md.
19. Aug 18 19 Mrs. W. R. S. Denner Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 15 19 45 at 9:05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from —— 19 to 19
and that I last saw h— alive on 19

Immediate cause of death	DURATION
Fracture Skull	
Due to: Automobile accident	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 8/15/45
Where did injury occur? Linebaro Carroll Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury: Struck by automobile Injured at work? No.

23. SIGNATURE: James T. Hook Deputy Medical Examiner
M. D. or other
Address: Westminster Md Date signed 8/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

★ 07911

Reg. Dist. No. 74

1. PLACE OF DEATH:

County Carroll

City or town Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 yrs 4 mos 16 da

Hospital, institution, or street address where death occurred Springfield State Hospital

How long in hospital or institution? 16 yrs 4 mos 16 da

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County

City or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Bessie Seliger

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	single

8.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 15 - 1906

8. AGE: Years 38 | Months 9 mos | Days 6 da | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore (Town, county, and state)

10. Usual occupation Saleslady

11. Industry or business Store

FATHER 12. Name Solomon Seliger

13. Birthplace Russia

MOTHER 14. Maiden name Rosa Goldstein

15. Birthplace Russia

16. Informant Mrs Edna Rappeport

Address 4103 Wentworth Rd Balto

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 23, 1945 (month) (day) (year)

Cemetery or crematory Baltimore Hebrew Cem.

Location Balto. Md.

18. Funeral director Jacob Lewis Inc.

Address 2100 Eutaw Place

19. Aug 22 1945 (Date rec'd by registrar) C. Henry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 22 1945 at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 5th 1929 to Aug 22 1945 and that I last saw h.. alive on Aug 22 1945

Immediate cause of death	DURATION
Coronary thrombosis	1 hr.
Due to Epilepsy	11 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W H Gaston MD M. D. or other

Address Sykesville Md. Date signed 8/22/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

07912

Reg. Dist. No. 83

1. PLACE OF DEATH:

County: Carroll

City or town: Gist

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years, 6 months

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Gist

(If outside city or town limits, write RURAL and give nearest town)

Street No. R,D. Sykesville

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: COLUMBUS A. SHIPLEY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ruth Ann Shipley deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 17, 1858

8. AGE: Years: 87 | Months: 3 | Days: 26 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Farmer---retired

11. Industry or business:

FATHER — 12. Name: John C. Shipley

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Brothers

MOTHER — 15. Birthplace: Maryland

16. Informant: Mr. W. Elbert Shipley

Address: Sykesville, Md.

17. (Burial, cremation, or removal. Which?) Burial — Date thereof: 8-16-45 (month) (day) (year)

Cemetery or crematory: Bethesda Cemetery

Location: Gist, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. (Date rec'd by registrar) Aug 14 1945 — Edna M. Hewitt, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13, 1945 at 4:50A: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1935 to Aug 13 1945 and that I last saw h... alive on Aug 12 1945

Immediate cause of death	DURATION
Myocarditis (chr)	
Nephritis (chr)	
Due to	
Uremia	7 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. C. Jamutte M.D. M. D. or other

Address: Westminster Md. Date signed: 8-13-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35)

07913

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 13 days
Hospital, institution, or street address where death occurred: Springfield State Hospital
How long in hospital or institution? 4 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)
Street No. 1410 Linden Ave. (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ruby Alberta Shirley

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	divorced

B.(b) Name of husband or wife: Reginald King Shirley
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): September 20, 1897

8. AGE:	Years	Months	Days	If less than one day
	47	10	25	hrs. min.

9. Birthplace: Toronto, Canada (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Francis Bell
13. Birthplace: Toronto Canada

MOTHER
14. Maiden name: Dorothy Wood
15. Birthplace: Toronto Canada

16. Informant: Hospital record
Address: Springfield State Hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/17/45 (month) (day) (year)
Cemetery or crematory: Lorraine
Location: Woodlawn Md.

18. Funeral director: William J. Tickner & Sons
Address: North & Pennsylvania Aves.

19. 8/16 (Date rec'd by registrar) 1945 a.W. Hedrich Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1945 at 6.01 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 14 1945, to August 15 1945 and that I last saw her alive on August 15 1945

	DURATION
Immediate cause of death: Chronic myocarditis	7 years
Due to:	
Due to:	
Other conditions: Incidental uterine malignancy	6 months

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Irene Hetherington, M.D. (M. D. or other)
Address: Springfield State Hosp. Date signed 8-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

07914

CERTIFICATE OF DEATH

Reg. Diat. No. 78

1. PLACE OF DEATH:

County Carroll

City or town Rural Taneytown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Rural Taneytown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harvey E. Shorb

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Martha Alice Shorb

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 28, 1869

8. AGE: Years	Months	Days	If less than one day
76	0	0	hrs. min.

9. Birthplace Nr. Taneytown, Maryland
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Edward Shorb

13. Birthplace Md.

MOTHER 14. Maiden name Ellen Martin

15. Birthplace Md.

16. Informant Dr. C.M.Benner

Address Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 31, 1945 (month) (day) (year)

Cemetery or crematory Keysville Cemetery

Location Keysville, Md.

18. Funeral director C.O.Fuss & Son

Address Taneytown, Md.

19. Aug 31 1945 (Date rec'd by registrar) Ethel M Mackley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28th 1945 at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 27th 1945 to Aug 28th 1945 and that I last saw him alive on Aug 28th 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. M. Benner M.D.
M. D. or other

Address Taneytown Md Date signed Aug 30th 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

07915

Reg. Diat. No. 71

1. PLACE OF DEATH:
County Carroll
City or town Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State County
City or town
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Cornelia Jane Shuey

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife John C. Shuey
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jan 6, 1860

8. AGE: Years 85 | Months 7 | Days 15 | If less than one day hrs. min.

9. Birthplace Md
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business

FATHER
12. Name John Myers
13. Birthplace Md

MOTHER
14. Maiden name Lydia Reinkee
15. Birthplace Md

16. Informant Mrs Glenn Crouse
Address Uniontown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 29 1945 (month) (day) (year)
Cemetery or crematory Burnt
Location Tyrone - Md

18. Funeral director Ed Dyer & Son
Address Taneytown, Md

19. Aug 24 1945 Margaret R England
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 21 1945, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 1945, to Aug 21 1945
and that I last saw h alive on Aug 20 1945

Immediate cause of death Cerebral Hemorrhage — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. N. Lugg M. D. or other
Address Union Bridge Date signed 8/23-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

07916

Reg. Diat. No. 71

1. PLACE OF DEATH:
County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Uniontown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lillie D. Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband ~~or wife~~: late Evans T. Smith
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 25 - 1872

8. AGE: Years	Months	Days	If less than one day
73	2	29	hrs. min.

9. Birthplace: Hancock, Maryland (Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: At home

FATHER
12. Name: John L. Shaw
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary Williams
15. Birthplace: Maryland

16. Informant: Mrs Virginia Watters
Address: Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 26-1945 (month) (day) (year)
Cemetery or crematory: Methodist Cemetery
Location: Uniontown Md.

18. Funeral director: W. H. Hartley & Sons
Address: Union Bridge & New Windsor, Md.

19. Aug 26 1945 (Date rec'd by registrar) Margaret R. Englar Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1945 at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1945, to Aug 23 1945
and that I last saw her alive on August 22 1945

Immediate cause of death: Arteriosclerotic C-V disease — DURATION: several yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: James T. Houck M. D.
M. D. or other
Address: Westminster Md. Date signed: Aug 28/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

07917

CERTIFICATE OF DEATH

Reg. Dist. No. 80

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Carroll
City or town Rural New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 19 yrs.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Carroll
City or town Rural New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Catherine Myrtle Stoner

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife C. Dewey Stoner
6.(c) If alive, give age 47 years

7. Birth date of deceased (mo., day, yr.) March 5 1900

8. AGE: Years	Months	Days	If less than one day
39	5	0	hrs. min.

9. Birthplace Carroll Co. Md. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name C. Edward Harner
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Sadie C.
15. Birthplace Md.

16. Informant C. Dewey Stoner
Address New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 8 1945 (month) (day) (year)
Cemetery or crematory Pipe Creek Cem.
Location Wakefield, Carroll Co. Md.

18. Funeral director H. Bankard & Son
Address Westminster, Md.

19. Aug 4 1945 (Date rec'd by registrar) Esau D. Bruchey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1945, at 7:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1944 to August 5 1945
and that I last saw her alive on August 5 1945

Immediate cause of death	DURATION
Carcinoma	
Ascending Colon	
Metastases	Sept 1943
Due to Sarcoma	
Cachexia	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. Glenn Speicher M. D. or other
Address Westminster, Md. Date signed 8/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07918

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 months, 7 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Sykesville,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: REUBEN FRANKLIN THOMAS

3.(b) Social Security Number: 220-05-8084

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): May 10, 1912

8. AGE: Years	Months	Days	If less than one day
33	3	20	hrs. min.

9. Birthplace: Sykesville, Maryland (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Alpheus Thomas
13. Birthplace: Sykesville, Md.

MOTHER
14. Maiden name: Bessie Dorsey
15. Birthplace: Howard County, Md.

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 2, 1945 (month) (day) (year)
Cemetery or crematory: Asbute Rock
Location: Sykesville Md
18. Funeral director: C. M. Walter
Address: Wansfield md.
19. Aug. 30, 1945 (Date rec'd by registrar) Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30, 1945, at 9:30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 23, 1944, to August 30, 1945
and that I last saw h im alive on August 30, 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	June 1943
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other
Address: Henryton, Maryland Date signed: 8-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07919

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs. 15 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 18 yrs. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Frederick

(If outside city or town limits, write RURAL and give nearest town)

Street No.: N. Bentz St.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: SUSAN WALLING

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	single

B.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1884

8. AGE: Years	Months	Days	If less than one day
61			hrs. min.

9. Birthplace: Frederick Md. (Town, county, and state)

10. Usual occupation: bookkeeper

11. Industry or business: —

FATHER 12. Name: unk

13. Birthplace

MOTHER 14. Maiden name: unk.

15. Birthplace

16. Informant: Hospital records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/4/45 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cem.

Location: Frederick, Md.

18. Funeral director: Harry E. Carty

Address: Frederick, Md.

19. Aug. 2 1945 C. Tracy Wood Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 2 1945 at 10:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1942, to Aug. 2 1945 and that I last saw h— alive on Aug. 2 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs.
Due to	
Due to	
Other conditions Psychosis, Polymorphic type	18 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arnold H. Eichert M.D. M. D. or other

Address: St. Hosp. Sykesville Md. Date signed 8-2-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-C)

07920

CERTIFICATE OF DEATH

★ Reg. Diat. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Millers

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Millers

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Everett Gardner Wareheime

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mch. 4 - 1890

8. AGE: Years: 55 | Months: 5 | Days: 27 | If less than one day: hrs. min.

9. Birthplace: Hampstead Carroll Co. Md.
(Town, county, and state)

10. Usual occupation: Lodgeman

11. Industry or business: Shoe Business

12. FATHER — Name: Richard Wareheime

13. FATHER — Birthplace: Maryland

14. MOTHER — Maiden name: Ella Virginia Gardner

15. MOTHER — Birthplace: Maryland

16. Informant: Carroll Wareheime

Address: Lineboro, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 3/45 (month) (day) (year)

Cemetery or crematory: Hampstead

Location: Hampstead Md

18. Funeral director: Eder & Tipton

Address: Hampstead Md

19. Sept. 2 1945 (Date rec'd by registrar) Mrs. W. R. S. Demuth Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 19 45, at 7.40 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 19 36, to Aug 31, 19 45, and that I last saw h... alive on Aug 31, 19 45.

	DURATION
Immediate cause of death: Coronary Occlusion	Suddenly
Due to: Chronic Myocardial Disease	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edgar M. Bush M. D.
M. D. or other

Address: Hampstead Md. Date signed: 8/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07921

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 11 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Maryland
How long in hospital or institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5609 Woodlock Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SQUIRE LOUIS WASHINGTON

3.(b) Social Security Number: 263-07-7883

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Evelyn Washington
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 22, 1912

8. AGE: Years	Months	Days	If less than one day
32	8	12	hrs. min.

9. Birthplace: Donalsonville, Georgia
(Town, county, and state)

10. Usual occupation: Welder

11. Industry or business

FATHER
12. Name: Square Washington
13. Birthplace: Newfall, Alabama

MOTHER
14. Maiden name: Josephine Belair
15. Birthplace: Alabama

16. Informant: Reuben Hoffman, M.D.
Address: Henryton, Maryland

17. Shipped (Burial, cremation, or removal. Which?) Date thereof 8-5-45 (month) (day) (year)
Cemetery or crematory: Bainbridge
Location: Georgia

18. Funeral director: Rayner Sanders
Address: 1412 E. Preston St

19. Aug. 3, 1945 (Date rec'd by registrar) Albert A. Trumbo Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3, 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23, 1945, to August 3, 1945 and that I last saw him alive on August 3, 1945

Immediate cause of death	DURATION
Intestinal Obstruction	2 days
Due to	
Due to	
Other conditions: Pulmonary Tuberculosis	Nov. 19 1944

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged ststistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D.
M. D. or other
Address: Henryton, Maryland Date signed: 8-3-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-R)

CERTIFICATE OF DEATH

07922

★ Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Oakland Mills
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Carroll

City or town: Oakland Mills
(If outside city or town limits, write RURAL and give nearest town)

Street No. Sykesville R.D.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Helen L. Wells

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W	Divorced

6.(b) Name of husband or wife: ?

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 11, 1902

8. AGE: Years: 43 | Months: 0 | Days: 21 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Stenographer

11. Industry or business: Woolen Mills

FATHER
12. Name: J. Harry Richter
13. Birthplace: Md.

MOTHER
14. Maiden name: Elizabeth R
15. Birthplace: Md.

16. Informant: Mr J Harry Richter
Address: Sykesville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 4, 1945 (month) (day) (year)

Cemetery or crematory: Lorraine Park Cemetery

Location: Woodlawn, Balto. Md.

18. Funeral director: C. Harry Wenz

Address: Sykesville, Md.

19. Aug. 3 1945 (Date rec'd by registrar) C. Harry Wenz Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 1 1945 at 10:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Aug. 1 1945 and that I last saw h-- alive on Aug. 1, 1945

Immediate cause of death	DURATION
Carcinomatosis	1 year
Due to: Cancer of Colon	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Wm. E. Martin M. D. or other

Address: Randallstown Date signed: 8/2/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 07923

1. PLACE OF DEATH:
County Carroll
City or town Henryton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mos., 23 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sahatorium (Colored Branch)
How long in hospital or institution? same as above

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 655 Stirling Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JULIA WILSON

3.(b) Social Security Number lost

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 25, 1921

8. AGE: Years	Months	Days	If less than one day
23	7	7	hrs. min.

9. Birthplace South Carolina (Town, county, and state)
10. Usual occupation waitress
11. Industry or business --

FATHER
12. Name Edmund Wilson
13. Birthplace Unknown

MOTHER
14. Maiden name Sarah Howard
15. Birthplace Unknown

16. Informant Reuben Hoffman, M.D.
Address Henryton, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 8/7/45 (month) (day) (year)
Cemetery or crematory
Location Sumter, S.C.
18. Funeral director Mrs. Samuel Hensley
Address 578 W. Biddle st.

19. Aug. 2 1945 (Date rec'd by registrar) Albert A. Trautman Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2 1945 at 5:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 9 1945, to Aug. 2 1945 and that I last saw her alive on Aug. 2 1945

Immediate cause of death	DURATION
Pulmonary tuberculosis	Dec. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben Hoffman M.D. M. D. or other
Address Henryton, Md. Date signed 8-2-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07924

Reg. Dist. No. 74

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 5 days

Hospital, Institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 554 Roberts St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: THOMAS WINSTON

3.(b) Social Security Number: 223-09-8395

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 31, 1913

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
31	7	3		

9. Birthplace: Richmond, Virginia (Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business:

FATHER — 12. Name: Willie Winston

13. Birthplace: Richmond, Va.

MOTHER — 14. Maiden name: Marie Payne

15. Birthplace: Richmond, Va.

18. Informant: Reuben Hoffman, M.D.

Address: Henryton, Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 8/6/45 (month) (day) (year)

Cemetery or crematory: University of Md School of Medicine

Location:

18. Funeral director: Frances H. Hunter

Address: 578 W. Baltimore St.

19. Aug. 3, 19 45 (Date rec'd by registrar) Albert R. Swarthout Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3, 19 45, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 29, 1945 19 to August 3, 19 45 and that I last saw him alive on August 3, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	March 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Maryland Date signed: 8-3-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

07925

CERTIFICATE OF DEATH

Reg. Diat. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: rural near Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yr., 7 mo., 19 days

Hospital, Insitution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Poplar Springs

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Ernest Woodward

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 6, 1890

8. AGE: Years	Months	Days	If less than one day
55	1	20	..... hrs. ..... min.

9. Birthplace: Howard County, Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business

FATHER 12. Name: William Woodward

13. Birthplace: Ohio

MOTHER 14. Maiden name: Ella Fluhart

15. Birthplace: Howard County, Maryland

16. Informant: Springfield State Hosp. records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal—Which?) Date thereof: Aug. 29, 1945 (month) (day) (year)

Cemetery or crematory: Poplar Springs Cemetery

Location: Poplar Springs, Md.

18. Funeral director: C. Harry Eiler

Address: Sykesville, Md.

19. Aug. 27 1945 (Date rec'd by registrar) C. Harry Eiler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 26 1945 at 1:25 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1943 to Aug. 26 1945 and that I last saw him alive on August 26 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	2 hrs.
Due to	
Due to	
Other conditions: Psychosis with organic brain disease, type not determined	life

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May, M.D.

Springfield State Hospital M.D. or other

Address: Sykesville, Maryland Date signed: 8-26-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

07927

CERTIFICATE OF DEATH

★ Reg. Diat. No. 72

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Pleasant Valley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME Mrs Fannie R. Yingling

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Edward C. Yingling
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1872

8. AGE:

Years	Months	Days	If less than one day
73	2	11	hrs. min.

9. Birthplace: Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Leonard Zile
13. Birthplace: Md

MOTHER
14. Maiden name: Margaret Stevenson
15. Birthplace: Md

16. Informant: Mr. Edward C. Yingling
Address: Westminster R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 28 1945 (month) (day) (year)
Cemetery or crematory: Pleasant Valley
Location: Pleasant Valley, Md.

18. Funeral director: C.O. Gist & Son
Address: Taneytown Md

19. Aug 28th 1945 (Date rec'd by registrar) Calvin T. Bankert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25 1945 at 11:50 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1945, to Aug 25 1945, and that I last saw her alive on August 25 1945

	DURATION
Immediate cause of death: Carcinoma	
descending Colon &	
metastases to abdomen	
Due to: wall types & lungs	
Secondary and/or	
Cachexia	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Ca. descending Colon
Date of op. June 20/45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. Glenn Beasley M. D. or other
Address: Westminster Md Date signed Aug 27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07926

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Carroll Co.

City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Yingling

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Mollie Smith Yingling

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 21, 1865

8. AGE: Years	Months	Days	If less than one day
80	6	26	....hrs. ....min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation carpenter and painter

11. Industry or business

FATHER
12. Name Edmund Yingling
13. Birthplace Md.

MOTHER
14. Maiden name Agnes Arntz
15. Birthplace Pa.

16. Informant Mollie Smith Yingling

Address Union Bridge R# 1

17. burial Date thereof Aug. 19 1945.
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Church of God Cemetery

Location Uniontown, Md.

18. Funeral director C.O. FUSS & SON

Address Taneytown, Md.

19. Aug. 17 1945 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 16 1945, at 7 P., M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945, to Aug 16 1945

and that I last saw h... alive on Aug 16 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. A. Mason M.D.
M. D. or other

Address Johnsville Date signed Aug 17

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07928

CERTIFICATE OF DEATH

Reg. Dist. No. 74

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 month, 13 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Maryland.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 46 S. Stockton Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM ROBERT YOUNG

3.(b) Social Security Number: 218-07-7390

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 24, 1913

8. AGE: Years	Months	Days	If less than one day
31	11	5	hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: George Young
13. Birthplace: Unknown

MOTHER
14. Maiden name: Viola Myers
15. Birthplace: Unknown

16. Informant: Reuben Hoffman, M. D.
Address: Henryton, Md.

17. 4 yrs. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/45 (month) (day) (year)
Cemetery or crematory: Mt Auburn.
Location: Baltimore md.
18. Funeral director: Mrs Katie R. Williams
Address: 322. N Schroeder St.

19. 8/29/ (Date rec'd by registrar) 19 45 Allen R. Swanberg Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29, 19 45, at 4.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 16, 19 45 to Aug., 29, 19 45 and that I last saw h er alive on August 29, 19 45

Immediate cause of death	DURATION
Pulmonary Tuberculosis	10-7-41
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed 8/29/45